and his Addison's disease might have been induced therefore by sarcoidosis rather than by "idiopathic" adrenal failure. If so, his wife could have contracted one or other of these diseases herself subclinically. The prolonged cellular immunity generated by sarcoidosis might have even triggered off her mammary carcinoma.⁶ Was raised immunity then responsible for the other malignancies in this family? A few tuberculous parents have had children who later developed sarcoidosis. The son in this family was found much later to have the coeliac syndrome. Was this also caused by the sarcoid agent?⁷ The answers to these questions are still unknown because not enough facts are yet available. But it is unlikely in the meantime that natural selection will eliminate the sarcoid agent.

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¹ Personal paper, *Lancet*, 1969, 1, 725.

² Karlish, A J, and MacGregor, G A, *Lancet*, 1970, 2, 330.

³ Kopelman, H, Case presented at Brompton Hospital, 1971.

⁴ Burns-Cox, C J, and Pearson, J E G, *Postgraduate Medical Journal*, 1972, 48, 115.

⁵ Irving, W, Personal communication.

⁶ MacGregor, G A, *Lancet*, 1973, 1, 1185.

⁷ MacGregor, G A, *British Medical Journal*, 1976, 2, 106.

Names of Asian women and babies

SIR,—The names of Asian women and their babies in maternity hospitals are giving rise to difficulties. The previous practice in our maternity hospital at Luton was to use the mother's name only. The surname used was part of the mother's name, so the surname was either Begum, in Moslem names, or Kaur, in Punjabi or Sikh names. We then found large numbers of Mrs Begums or Mrs Kaurs, both names in their native language meaning "Mrs." The babies were then called Baby Begum or Baby Kaur. This created various hazards, as follows: (1) The wrong baby could have been given to the wrong mother. (2) When discharged, the baby was given another name; he was no longer Baby Begum or Baby Kaur; thus there was no continuity of records for the child. (3) There were no means of relating the name of the baby to the mother's or father's name, as there was no way of relating the mother as the wife of her husband, who would have a separate name. (4) It was impossible to keep accurate notifications of infectious diseases, records of BCGs given, and other public health records.

As surnames do not exist in the Asian sub-continent they have another system of keeping track of their teeming millions. The method used is: person's name, followed by the father's name, and then the caste name. This applies mainly to the Hindus. The Moslems can use the same system, using the father's name as a surname, except a few families that have adopted a family name related to a trade, a place, or a title.

I propose that we adopt a system not only in hospitals but in the community health service and in general practice that is similar to the Asian system, but modified so as to be acceptable both to the immigrant and to us.

We find the majority of these mothers are illiterate in their own mother tongue and need help from interpreters. The interpreter who first helps to register the new patients at the maternity hospital asks (1) the patient's name,

(2) the husband's name, (3) the family name, if one exists. If no family name is used the husband's name is entered as the surname, hyphenated if necessary. For example, Mrs Akhtar Mohammed-Hussain is Akhtar, the wife of Mr Mohammed-Hussain. Their child would be Baby (male or female) Mohammed-Hussain. Similarly, for the Sikhs, the mother would be known by her first name—for example, Amrit, wife of Pratap-Singh, as Mrs Amrit Pratap-Singh. This system identifies the family under the name of the head of the family—the husband. For the records the name would be recorded under the first part of the hyphenated name. The whole family would use that as the surname. We found the old system intolerable and this new system much more workable. I am sure that other hospitals in cities with large Asian immigrant populations must have similar problems and suggest that our system is tried.

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Diagnosis of Down's syndrome at birth

SIR,—For those who have the unenviable task of "breaking the news" your leading article (9 October, p 835) is very informative and demonstrates clearly the clinical difficulties that may be met. But the brief mention of "early supportive management" hardly does justice to the enormity of the task. There is no blue-print, and each doctor has to work out for himself how best to manage this crisis situation. A working party¹ on the subject pointed out the problems involved and emphasised the far-reaching implications of the initial way in which parents learned of their child's condition. It is never a task to be undertaken lightly or by the inexperienced, and it is because it is a time of such importance that I feel the need to point out the omission.

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¹ Carr, E F, *et al*, *Lancet*, 1971, 2, 1075.

Community health councils and the public

SIR,—Your correspondent Dr S L Sacks complained (18 September, p 701) that he was not allowed to take part in the debate at the September meeting of the Peterborough Community Health Council and that he was not given a copy of the agenda.

Certainly one way of discovering the views of members of the public would be to encourage people to join in discussions at our monthly meetings. But unfortunately this would just not be practicable. We have barely adequate time to allow all the Community Health Council members to make their contributions. However, we do from time to time hold additional public meetings for the sole purpose of listening to what people have to say about their health services. Our office is open every weekday, and our members are available to anyone who wishes to discuss health matters with the Community Health Council.

These are just some of the ways in which we encourage the public's involvement in our activities and in their health services. We do also welcome people to attend our monthly

business meetings, to listen to our debates, and talk to us afterwards. May I assure Dr Sacks that in future members of the public will be provided with the relevant papers. We have tried not to let our secretary's many months' absence due to sickness affect our service to the public. On this occasion it did, and I apologise.

I am sorry that Dr Sacks reached his conclusions after attending just one part of one meeting. I have the feeling that if the Community Health Council reached such a conclusion after such a cursory inquiry and then made it public we would be labelled as irresponsible.

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CMV retinitis

SIR,—Having recently reviewed the subject of cytomegalovirus (CMV) retinitis in adults¹ I read with interest the report of Mr Chawla and others (31 July, p 281) which presented an otherwise healthy woman with this infrequent manifestation of CMV infection. Although the authors state that there have been only six reports of CMV retinitis in adults, we found a total of 19 cases in the English literature.²⁻¹⁴ We reported two additional patients as well. Thus, despite CMV infection being reasonably common in the general population, retinitis still remains an unusual complication.

CMV retinitis has occurred almost exclusively in immunologically compromised patients (18 of the 21 were renal transplant recipients, one had breast carcinoma, one had Hodgkin's disease). However, the first description of adult CMV retinitis² was in a woman who, like the patient of Chawla *et al*, was also apparently healthy. Although a minor point, the authors should amend the statement about theirs being the first reported case of this association.

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¹ Murray, H W, *et al*, *American Journal of Medicine*, in press.

² Foerster, H W, *Survey in Ophthalmology*, 1959, 4, 296.

³ Smith, M E, *Archives of Ophthalmology*, 1964, 72, 44.

⁴ Maler, G H, and Kisker, W A, *American Journal of Surgery*, 1970, 119, 334.

⁵ de Venecia, G, *et al*, *Archives of Ophthalmology*, 1971, 86, 44.

⁶ Aaberg, T M, Cesarz, T J, and Rytel, M W, *American Journal of Ophthalmology*, 1972, 74, 407.

⁷ Madge, G E, *Medical College of Virginia Quarterly*, 1972, 8, 251.

⁸ Porter, R, *et al*, *British Medical Journal*, 1972, 3, 133.

⁹ Porter, R, *British Journal of Ophthalmology*, 1972, 56, 555.

¹⁰ Wyhinny, G J, *et al*, *American Journal of Ophthalmology*, 1973, 76, 773.

¹¹ Coulson, A S, *et al*, *Western Journal of Medicine*, 1974, 120, 1.

¹² Astle, J N, and Ellis, P P, *Annals of Ophthalmology*, 1974, 6, 1269.

¹³ Fiala, M, *et al*, *Journal of Infectious Disease*, 1975, 132, 421.

¹⁴ Oberman, A E, and Chatterjee, S N, *Western Journal of Medicine*, 1975, 123, 184.

Postinfluenza depression

SIR,—Dr T H Flewett's letter (2 October, p 815) notes a lack of correlation between hospital admissions for depression and the occurrence of influenza outbreaks. This may be due to the fact that depression following influenza is usually mild, usually goes un-